For Healthier Lives

Massachusetts Department of Public Health

Communicable Disease Update

Newsletter of the Bureau of Communicable Disease Control

Volume 4 | Issue 4 | October 1996

Screening kids for TB—new recommendations

Since 1992, the case rate of tuberculosis in Massachusetts has declined by 25%. Due in part to this declining case rate, the Massachusetts Department of Public Health (MDPH) has issued changes to the TB skin test guidelines. Previously, the MDPH recommended that all children be routinely skin tested for TB by the age of five, or before entering the school system. Also, while the MDPH strongly recommended the Mantoux (5TU-Intermediate PPD) test, the health care provider selected the type of skin test used. Now, for the reasons described below, these recommendations have changed. The Medical Advisory Board of the Massachusetts Committee for the Elimination of Tuberculosis has produced new skin testing recommendations. The skin testing guidelines from the Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) form the basis for these recommendations. Implementing these changes will align Massachusetts policy with the CDC and the AAP.

1. Use ONLY the Mantoux test. Discontinue multiple puncture tests (MPTs) because:

- The Mantoux test is more accurate than MPT tests (TINE and Monovacc), which produce large numbers of both false negative and false positive results.
- Massachusetts has a low prevalence of TB infection; consequently there is a higher probability of positive MPT test results being false positive.
- False negative results in high-risk children may lead to serious consequences.
- Parents often interpret MPT test results incorrectly.

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New condom design

FDA approval is being sought for a new type of nonlatex condom that unrolls in either direction. This feature is expected to reduce the chances of placing the condom on the wrong way and contaminating the outside with semen before use. While experience with this new design is limited, it could overcome some of the reasons that traditional condoms are either not used or used incorrectly. The manufacturer claims that it is easier to put on than traditional condoms, and fits more loosely, thereby allowing greater sensation. Ease of use—even in the dark—may also help promote condom use by reducing embarrassment. This nonlatex condom, called PolyMAXX, may be on the market within the next couple of years.

Rabies warning for travelers

A 32-year-old New Hampshire woman died of rabies in August at Massachusetts General Hospital. The woman was bitten by a stray dog in June 1996 while traveling in Nepal. She sought medical advice, obtained conflicting information, and did not receive rabies postexposure treatment.

This is the second case of human rabies reported in the United States during 1996. The first was reported in Florida and also implicated a variant of the virus associated with rabid dogs, from exposure near the Mexico/Guatemala border. Canine rabies remains a human public health threat in many developing countries. Twelve (40%) of 30 human cases of rabies reported in the U.S. since 1980 were acquired outside of the country and were associated with dog variant rabies viruses.

Preexposure rabies vaccination should be offered to persons who will be visiting for more than 30 days, or are planning to reside in foreign countries where canine rabies is endemic. Travelers are at highest risk in El Salvador, Guatemala, Mexico, Peru, Colombia, Ecuador, India, Nepal, the Philippines, Sri Lanka, Thailand, and Vietnam. Rabies is also found in dogs in other countries of Africa and in Central and South America. The Centers for Disease Control and Prevention advises travelers to avoid contact with dogs and other animals, and rabies preexposure immunization is recommended for persons planning to stay in these areas for 30 days or more. Preexposure vaccination does not eliminate the need for additional therapy after exposure to a potentially rabid animal, but it simplifies the treatment by eliminating the need for rabies immune globulin and by decreasing the number of doses of vaccine required. Rabies biologics may not be readily available in all developing countries.

Persons who are bitten or scratched by any animal should immediately wash the wound for at least ten minutes with soap and water and promptly seek medical attention to evaluate the need for postexposure prophylaxis. For travel health information, call (617) 983-6800, or the CDC travel line at (404) 332-4559, or visit the CDC homepage on the world wide web at http://www.cdc.gov/travel/rabies.htm

Inside

Epidemiology Update

Cyclospora

From May through July 1996, 133 laboratory-confirmed cases of *Cyclospora cayetanesis* were reported to the Massachusetts Department of Public Health by laboratories throughout the state. Most of the cases were sporadic, but some were associated with common sources of infection at social events. At the same time, other states and the Canadian province of Ontario were reporting similar increases in sporadic and event-associated cyclospora cases. Preliminary analyses of both sporadic and event-related cases have associated many cases with consumption of raspberries imported from Guatemala. It has not yet been determined how raspberries were contaminated, although it is generally believed to have occurred prior to export. No new cases of cyclospora in Massachusetts have been reported since the end of July.

The first known human cases of cyclospora infection were diagnosed in 1977, and cases have been reported with increasing frequency since the mid-1980s, in part because of better techniques for detecting the parasite in stool. Since cyclospora infection is not yet a reportable disease in Massachusetts, statistics on background levels of infection have not been established. Cyclospora infection occurs after ingestion of food or water contaminated with the infectious form of this parasite. Unlike other organisms, however, cyclospora does not become infectious until days to weeks after it is excreted into stool; therefore, direct person-to-person transmission is unlikely. Transmission can occur when there is contamination of a food product or water source (*e.g.*, raspberries) with exposure occurring later, after the parasite has had time to become infectious. *Cyclospora cayetanesis* is a single-cell parasite that can be identified in stool. It infects the small intestine and typically causes an illness characterized by prolonged watery diarrhea. Other symptoms can include loss of appetite, weight loss, bloating, gas, stomach cramps, nausea, vomiting, fatigue, muscle aches, and low-grade fever. Some infected individuals experience no symptoms. The incubation period can range from several days to a week or more. If not treated, the illness may last for a few days to a month or longer and may relapse one or more times. It is not known whether immune-compromised persons experience a more serious illness with this infection.

Cyclospora can be treated with a regimen of sulfa-containing drugs such as trimethoprim-sulfamethoxazole. Treatment regimens for patients who cannot tolerate sulfa have not been identified. Infected persons with diarrhea should rest and drink plenty of fluids. Based on current information about the spread of cyclospora, preventive measures include thorough washing of fresh fruits and vegetables before eating. People infected with cyclospora should thoroughly wash their hands after stooling to prevent the spread of infection and should refrain from food preparation. People who have had cyclospora infection can become reinfected.

New bat booklet

Collaborating state agencies have published a booklet about bats and rabies in Massachusetts. It contains facts about rabies prevention, tips about removing bats from your home, etc. It is a collaborative effort between the Massachusetts Department of Public Health (MDPH), the Massachusetts Department of Food and Agriculture, Bureau of Animal Health and the Massachusetts Division of Fisheries and Wildlife. The booklet, titled ***Rabies and Bats in Massachusetts***, is available from the Division of Epidemiology and Immunization, Bureau of Communicable Disease Control, 305 South Street, Jamaica Plain, MA 02130.

Watch your mailbox!

On July 31, Connaught's Tripedia vaccine was licensed for use in infants and children 2 months of age and older. The Massachusetts Immunization Program (MIP) will soon begin providing this combined vaccine containing diphtheria, tetanus, and acellular pertussis vaccines. If you currently use MIP-supplied DTP vaccine, watch your mailbox for important information about Tripedia.

Adolescent school health courses

Day-long educational courses are planned for school nurses, boards of health, VNAs and others involved in implementing school-based adolescent health programs.

October 21, 1996 Amherst
October 25, 1996 Boston
October 29, 1996 Lowell

Topics to be covered include adolescent hepatitis B immunization, vaccine preventable disease morbidity, hepatitis B vaccine issues, school immunization regulations, school surveys, the new TB recommendations for school-age children, and community resources for schools. This course is accredited for five nursing CEUs.

For additional information call Dr. Patricia Piessens at the School Health Institute (508) 999-8249 or Gail H. Chaffee, RN, Adolescent Hepatitis B Coordinator, Massachusetts Immunization Program (617) 983-6800.

STD Update

Advisory group formed

The first meeting of the Advisory Group on Sexually Transmitted Disease and Women's Health was held on June 4. The meeting drew participants representing a variety of interests and agencies. A brief review of the epidemiology of sexually transmitted disease in women was followed by an overview of the work of the Division of STD Prevention.

The members worked in small groups to discuss priority issues regarding women and sexually transmitted diseases. These issues form the basis of a needs assessment and planning document that will be distributed to all members for further input. Some areas for collaboration have already been identified. The purpose of the Advisory Group is to foster cooperation among members, as well as provide advice to the Division of STD Prevention and other agencies.

STD education

STD/HIV/TB Management in Correctional Settings

October 24, 8:00–12:30 at the STD/HIV Prevention Training Center of New England. CMEs and nursing CEUs will be available. For information call (617) 983-6945.

Family Planning for Advanced Practice

October 25 and 26, 7:30–5:00. Includes discussion of STDs within context of family planning. Cosponsored with ABCD/Boston Family Planning. 16.5 nursing contact hours. For information and registration call Shelly Mains at ABCD, (617) 357-6000, x235.

Three-Day STD Intensive

November 18–20. Twelve hours of home study followed by 24 hours of on-site training consisting of clinical practicum, case studies and laboratory workshop. Course designed for clinicians who wish to update basic STD theoretical knowledge and management of STDs in ambulatory primary care settings. For more information call (617) 983-6945.

1996 Annual STD Update

December 4. STD/HIV Prevention Training Center of New England and Massachusetts Health Research Institute initiative. Seven-credit hours of category 1 CMEs (5 qualify for risk management credit). Nursing CEUs also available. For more information call (617) 983-6945.

National survey of partner notification

Identifying susceptible people who have been exposed to health-threatening infections and fashioning a protective intervention is at the heart of public health practice. Partner notification (PN) is a standard protective intervention for sexually transmitted diseases (STDs). PN has worked, particularly well against bacterial STDs, which can be cured or prevented with antibiotics. With the advent of viral STDs, PN services are being looked at in a new light: Is the service beneficial if the infection cannot be cured?

To see what policies and models of service are used to shape PN services in different states, the Massachusetts Division of STD Prevention conducted a national survey of STD and other infectious disease prevention programs. Surveys were sent to the director of each STD project area in the U.S. and its territories in June 1995. Preliminary results from this survey appeared in volume 4, issue 2 of *CD Update (April 1996);* final results are below.

Responses from 49 (76%) project areas were received and analyzed. The majority of respondents conduct PN as policy, although 15 respondents said that offering the service was mandated by law. There were written protocols for PN in 41 (83.7%), and 38 (79.6%) had written protocols on how to counsel partners. Forty-two (85.7%) provided formal training to the people who did the notification. Three basic models were used: patient referral, conditional referral and provider referral. Patient referral occurs when the infected person notifies his or her partner directly. Conditional referral involves an agreement between the patient and the health department's disease intervention specialist (DIS), who investigates cases of STD to stop transmission. The patient agrees to inform his or her partners. If the partners have not been seen by a medical provider within a specified time, the DIS commences notification. In provider referral, the DIS does the notification on behalf of the patient. Different types of PN were emphasized for different STDs.

Evaluations of PN concentrated more on process (*e.g.*, number of contacts elicited per case [47/49], percentage of contacts located [45/49], percentage of contacts treated prophylactically [45/49]) and less on cost-benefit [21/49] or outcome (*e.g.*, percentage of contacts accepting services [30/49], measures of behavioral change [7/49]).

These data suggest that there is strong support for PN as a disease prevention tool among STD programs. Public health literature has many citations attesting to the preventive impact of PN. Indeed, recent increases of syphilis in Baltimore and Los Angeles after reducing epidemiologic staff provide evidence of PN's importance. However, particularly in regard to viral STDs, more evaluation needs to be done of PN's role as a stimulus of behavioral change.

Regional Update: TB

Metro Boston Region—TSA 2 (508) 851-7261, Ext. 48 or (617) 727-7908, Ext. 48 **TSA Nurse** Jo-Ann Keegan, RN, MS

Personnel

Kenedy Mondesir was recently welcomed as a new community outreach worker for the entire TSA 2 region. Kenedy is fluent in Creole, Spanish and French and works closely with many at-risk patients. The Metro Boston Region, also known as TSA 2, includes suburban Boston west to Framingham, north to Wakefield and south to Norfolk County. The office is located on the grounds of Tewksbury Hospital in the Regional Health Office.

Epidemiology

In 1995, 58 cases of TB were diagnosed in TSA 2, 18% of the state's 330 cases for that year.

A review of cases in children (< 15 years of age) in TSA 2 was recently done. For the last 5 years (1991–95), there were 12 cases of tuberculosis verified in children. No cases in children have been reported in TSA 2 yet this year. A profile of these cases among children over this period showed that all but one child belongs to an identified high-risk group. This review indicates that as tuberculosis rates in the general population, and in children in particular, continue to decline, the challenge of health care personnel will be to focus screening on those children at risk of exposure.

Clinical Services

Clinical services for TSA 2 are currently provided free in the following locations: Cambridge Hospital; St. Elizabeth's Hospital, Brighton Marine Health Center; MetroWest Medical Center, Framingham Campus, and Middlesex County Hospital in Waltham.

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David H. Mulligan, Commissioner

For a free subscription, please call Debra Thimas at (617) 983-6800.

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Save the dates!

November 6
Immunization Tracking Committee Quarterly Meeting, 9:30–11:00 in the Auditorium at the State Laboratory Institute, 305 South Street, Jamaica Plain. Call Robert Rosofsky at (617) 983-6836 for more information.

November 21
NECON: New England Coalition for Health Promotion and Disease Prevention will hold its annual regional forum. The topic this year is "The Role of Government in the Evolving Health Care System." Call Carol McCullogh, NECON Conference Coordinator, at (508) 252-3146 for more information.

November 21
Western & Central Regional TB Conference for public health nurses and other health care workers interested in TB prevention and control. For information call Evelyn Thomas at (413) 736-8939.

December 5
"Surveillance of Vaccine-Preventable Diseases," 1:00–3:00. A live interactive satellite videoconference including guidelines for vaccine-preventable diseases, case investigation, and outbreak control. Call Donna Rosen, Massachusetts Nurses Association at (617) 821-4625 x719 for locations and registration information.

Regional Update: Immunization

Metro (617) 983-6860 **Admin. Assistant:** Carolyn Thames **Nurse:** Peg O'Toole, RN

Morbidity

Pertussis continues to be the major source of morbidity in the Metro Region over the summer. Three outbreaks were apparent at the close of school in June. Regional schools covering the towns of Norfolk, Wrentham, and Plainville as well as Lincoln and Sudbury lead in number of cases. There was also an outbreak in Holliston that was associated with sports teams in the Norfolk-Wrentham-Plainville schools.

We urge providers to seriously consider pertussis in any patient with a cough of two weeks or more.

Personnel

Lisa Berger has left her position as epidemiologist to pursue a dream to travel. We will all miss Lisa very much. We're grateful for all her hard work and for what she taught us about pertussis!

Please direct any calls concerning vaccine preventable disease or vaccine distribution to Peg O'Toole or Carolyn Thames. Plans are underway to fill the vacant Metro epidemiologist position.

Christine Johnsen, the Immunization Epidemiology Coordinator, has also left to pursue other interests. We will miss her, too, and wish her success in all her future endeavors.

Your Prevention Centers

See Massachusetts Prevention Centers article on page 6.

Greater Western MA (413) 584-3880, CHNA 1,2,3
Lower Pioneer Valley (413) 732-2009, CHNA 4
Greater Framingham/S Central MA (508) 875-5419, CHNA 5,6,7
Greater Worcester/N Central MA (508) 752-8083, CHNA 8,9
Merrimack Valley (508) 688-2323, CHNA 10,11,12
West Suburban/North Shore (508) 745-8890, CHNA 13,14,15
Metro/Suburban MA (617) 441-0700, CHNA 16,17,18
Boston (617) 423-4337, CHNA 19
Metro/Southeast MA (508) 583-2350, CHNA 20,21,22,23
Southeast Coastal MA (508) 996-3147, CHNA 24,25,26,27

Clarification

Hepatitis B needle tips

The Massachusetts Immunization Program is now providing hepatitis B vaccine for **adolescents** in prefilled syringes with one-inch needles and the appropriate dose.

It's here!

Varicella vaccine is now being distributed in Massachusetts. To find out how to order it for your practice, call Lois Ciccone in the Vaccine Management Office at **(617) 983-6812.**

You be the epi!

As a field worker (disease intervention specialist) within the Division of STD Prevention you get three reports of syphilis from three different sources within a two-week period. Patient #1 is a 41-year-old male who went to a local ER complaining of urethral discharge and inguinal adenopathy. He was diagnosed with recently acquired syphilis (RPR 1:128 and MHA-TP reactive) as well as urethritis. Patient #2 is a 23-year-old male whose blood work upon admission to a county jail revealed previously unrecognized secondary syphilis who had a history of rash involving the palms and soles (RPR of 1:128 and MHA-TP reactive). Patient #3 is a 28-year-old female who, on admission to drug treatment, had a routine syphilis serology (RPR of 1:128 and MHA-TP reactive) without other symptoms. All three patients have a history of illicit drug use. Are these cases related and how might they be related?

Analysis

After finding each of the patients (which took good field work because two of the patients gave false addresses and one gave a false name), you conduct interviews. While patient #1 identifies two women as sexual partners, neither is patient #3. Both partners have negative serologies but are treated to prevent syphilis. Patient #2 also identifies two female contacts who are roommates. Both have syphilis and are treated. Patient #3 will not divulge any contacts during the interview. She says that she will notify the people that need to be told. You end the interview by giving her your business cards to give to people she notifies. Five people come in as a result of her notification. All five of those contacts are treated prophylactically.

While a relationship among these three clients was not established during the interviews, you find that these clients not only know each other, but live within several blocks. Two of them are neighbors. Very likely these cases are interrelated. This cluster investigation is still ongoing and interviews are still being conducted. It is unclear how widespread it may be. The relationship among these cases would never have been apparent without thorough field work. This shows how important it is to thoroughly investigate all new cases and to interview clients and their contacts until all contacts have been identified and treated.

Immunization Update

Massachusetts Prevention Centers: Working together to build healthy communities

The ten Massachusetts Prevention Centers compose a statewide training and technical assistance system established in 1979. These Prevention Centers are funded cooperatively by the MDPH Bureaus of Substance Abuse Services, Family and Community Health, HIV/AIDS, and Communicable Disease Control; the Executive Office of Public Safety; and the Massachusetts Department of Education.

The Prevention Center system is based on the following premises: 1) communities should be involved in disease prevention and health promotion planning, 2) technical and human resources must be available to support community planning, implementation and evaluation activities, 3) efforts are enhanced when communities have opportunities to establish linkages with other agents of change, and 4) public awareness of health issues and available resources are essential for communities to take action.

The Prevention Centers serve local coalitions, school systems, municipalities, Community Health Network Areas (CHNAs) and other community health planning and disease prevention initiatives. Their staffs promote participation in community initiatives across the state and are trained in several community health planning and development models. Prevention Center staffs also use a train-the-trainer model to provide health education training on a range of health issues including immunizations, HIV/AIDS, alcohol and other drugs, tobacco, nutrition and injury. Each Prevention Center has a resource library, which provides residents, community organizations and other groups access to a wide range of books, journals, pamphlets, videotapes and films, multicultural resources and on-line databases.

Communicable disease activities include a statewide immunization initiative to improve access to and utilization of immunization services. The Springfield Prevention Center is collaborating with the Division of STD Prevention, youth peer leaders, and other community organizations to educate youths, medical providers and parents about STD and sexuality issues faced by teens. The Brockton Prevention Center, in collaboration with MDPH, local Haitian and Cape Verdean organizations and health care providers, is working to increase community knowledge and awareness of TB, STDs and HIV and to improve access to related medical services. For Prevention Center locations see page 5.

Now's the time

Fall is the season for making sure that your adult patients are up to date on their vaccinations. Recent studies have shown that risk factors for influenza, pneumococcal disease, tetanus and diphtheria increase after age 50. To help prevent these diseases, the Massachusetts Immunization Program (MIP) provides pneumococcal, influenza, and tetanus-diphtheria (Td) vaccines for adults. These vaccines are also available for younger individuals who need them because of medical conditions or other risk factors.

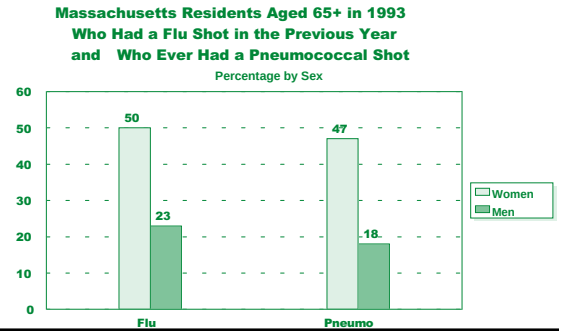
Flu, pneumococcal and Td vaccines can be safely and effectively administered simultaneously, as long as different anatomical sites are used. Therefore, the MIP encourages providers to use annual flu shot visits as an opportunity to assess their patients' need for pneumococcal and Td vaccines.

Pneumonia and flu are the fourth leading cause of death among the state's residents aged 65 years and older. According to the 1993 Behavioral Risk Factor Survey, only half of residents aged 65 and older had received flu shots in the preceding year and only 22% had ever received pneumococcal vaccine. Interestingly, immunization rates in women were more than double those in men, as shown in the accompanying graph.

According to the Centers for Disease Control and Prevention (MMWR1996:45(RR-5)), 52% of U.S. seniors and an estimated 30% of younger high-risk individuals got flu shots. Nationally, only 28% of those at risk for pneumococcal disease are estimated to be vaccinated. Immunization levels for both vaccines are substantially lower among black and Hispanic Americans.

In an effort to improve vaccination levels in Massachusetts, the Adult Immunization Coalition is focusing public education efforts on the state's black and Hispanic communities. One strategy is to recruit community leaders to receive their vaccinations publicly, during locally well-publicized events. Health care providers in the area can assist such efforts by participating in these events and by reviewing medical records to identify their high-risk patients in need of immunization.

Mid-October to mid-November is a good time for conducting organized vaccination campaigns. However, high-risk individuals can and should be vaccinated any time from early October through the end of the flu season.



New recommendations

(Continued from page 1)

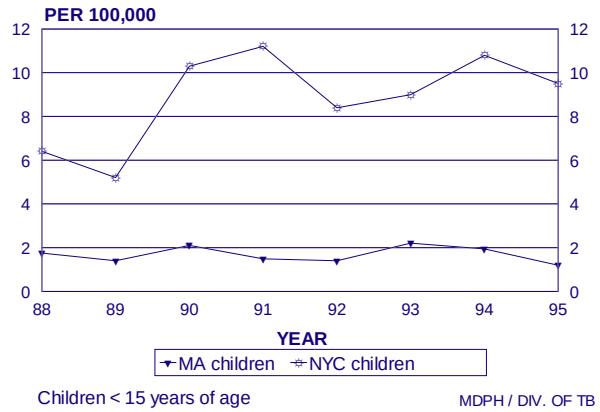
2. Test ONLY children at risk of exposure to TB because:

- Inappropriate testing of low-risk children predictably produces false positive test results leading to unnecessary concern and inappropriate treatment.
- Selective testing of those at higher risk of exposure focuses time, energy and resources on the population that will most benefit from preventive treatment.
- Limiting screening to higher-risk infants and children increases the incentive for test reading and follow-up.
- Risks associated with unnecessary treatment of uninfected infants and children are minimized.

3. Eliminate school TB skin test requirement based on geographic risk because:

- Even the highest prevalence communities in Massachusetts do not have a prevalence high enough to justify Mantoux skin tests for all children in the community.

Comparison of TB case rates between children of Massachusetts and New York City, 1988 –1995



Children < 15 years of age

MDPH / DIV. OF TB

The identification of at-risk populations is based on epidemiological data. A high-risk neighborhood or community does not automatically mean that an entire city is at high risk. Nor does it necessarily mean that an individual living in that neighborhood or community is at high risk.

The recommendations contain a questionnaire that health care providers can use to determine a child's risk of TB exposure. A child with an elevated risk of exposure should have a Mantoux skin test.

The questionnaire asks parents these questions:

- Has your child lived with or spent time with anyone who possibly or definitely had tuberculosis or had a positive skin test for tuberculosis?
- Did you (parent or guardian), your child, or anyone else living in your household come to the United States from another country? (Providers will be given a list of high TB prevalence countries.)
- Has your child lived with or spent time with adults who:
  - Were homeless, living either on the street or in a shelter?
  - Have a medical condition that would put them at higher risk for TB (silicosis, HIV infection, steroid therapy, etc.)
  - Used intravenous drugs or other street drugs?
  - Lived in a correctional facility (prison), nursing home or mental institution?

Mantoux test results should always be read by a health professional. A Mantoux test result is considered positive at three different levels (≥5, ≥10 and ≥15 mm) of induration depending on the individual's degree of risk of tuberculosis.

- If a child has no known risk for TB, then only a large reaction (≥15) is considered positive.
- If a child is very young (<4), has other medical risk factors, or has some environmental exposure to TB then an intermediate reaction (≥10) is considered positive.
- If a child has a high risk (for example, a child who lives in a household with someone who has TB) then a small reaction (≥5) is considered to be positive.

Screening School Children for Tuberculosis (TB)

Include a reminder that the pupil is due to have a TB risk assessment when a notice is sent to the child's home at the time of scheduled physicals and upon entry into the school. The MDPH Division of TB Prevention & Control will draft a letter that school nurses can send to parents and private providers. It is not the responsibility of the school nurses to evaluate the child to determine the risk of exposure to TB, the necessity for a TB (Mantoux) test, follow-up on positive reactors or children placed on isoniazid (INH) preventive therapy. Responsibility rests with the primary care providers. The school nurse may choose to check a child's TB (Mantoux) test or monitor preventive therapy at the request of the private provider.

Questions can be answered by the nurse for your Tuberculosis Surveillance Area (TSA).

TSA 1 - Carol Cahill, RN, Western & Central Regions (413) 736-8939
TSA 2 - Jo-Ann Keegan, RN, MS, Greater Metro Boston (508) 851-7261, x 48 or (617) 727-7908
TSA 3 - Nancy Taylor Flynn, RN, BS, Northeastern Region (508) 851-7261, x 50 or (617) 727-7908
TSA 4 - Susan Yoon, RN, MS, Boston TB Program (617) 534-4585 or (617) 534-4875
TSA 5 - Anne Empey, RN, Southeastern Region (508) 947-1231

Communicable Disease Updates
January — June 1995 vs. January — June 1996: Reported Cases

DISEASE	1995	1996*	% change from 1995
AIDS	718	604	-16%
Botulism	0	0	0%
Campylobacter	695	610	-12%
Chlamydia	3,401	2,729	-20%
Cryptosporidiosis	17	30	+76%
E. coli O157:H7	38	40	+5%
Giardiasis	389	367	-6%
Gonorrhea	1,200	901	-25%
Hepatitis A	69	99	+43%
Hepatitis B (acute)	67	37	-45%
Lyme Disease	91	83	-9%

DISEASE	1995	1996*	% change from 1995
Measles	2	9	—
Meningitis (Neisseria)	19	16	-16%
Pertussis	181	332	+83%
Rabies (animal)	295	51	-83%
Rubella	6	20	—
CRS**	0	0	0%
Salmonellosis	685	733	+7%
S. typhi (Typhoid)	28	9	-68%
Shigellosis	114	126	+11%
Syphilis (early)	119	113	-5%
TB	113	85	-25%

* Preliminary data. Reporting not yet complete.

** Congenital Rubella Syndrome

COMMUNICABLE DISEASE
UPDATE
STATE LABORATORY INSTITUTE
305 SOUTH ST.
BOSTON, MA 02130

Bulk Rate
US Postage
PAID
Boston MA
Permit No.
55970

Maintain that cold chain!

Distribution of varicella vaccine was recently implemented in Massachusetts. **This vaccine is very temperature sensitive!** In fact, proper handling and maintenance of the cold chain is crucial to the effectiveness of **all** vaccines. A vaccine inactivated by a break in the cold chain can be dangerously ineffective.

The Massachusetts Immunization Program suggests that one individual in a practice be designated as the "vaccine manager" to be responsible for ordering vaccine, ensuring that vaccines are stored properly, and recording usage. The "vaccine manager" would train all individuals handling and administering vaccines about specific storage requirements, stability limitations of vaccines, as well as correct recording of use. When unsure of vaccine storage requirements, *always refer to the package insert*. Listed below are some key guidelines for safe vaccine storage and handling in your office:

- The refrigerator and freezer should each have a thermometer. The temperature range for the refrigerator should be 35°– 46° F (2°– 8°C).
- The temperature for the freezer should be 5°F or lower (-15°C or lower).
- Check and record temperatures twice daily.
- Stack vaccine neatly, with space for accessibility and air flow.
- Rotate vaccine stock, using the vaccine with the shortest expiration date first.
- OPV and varicella vaccine must be stored in the freezer.
- All other vaccines must be refrigerated.
- Do not store vaccine on the doors of the units.
- Store ice packs in the freezer compartment.
- Responsible vaccine management and accountability is critical to ensure that Massachusetts will continue to have adequate stores of vaccine available, and that patients will receive potent and effective vaccines.